

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. DEC 12 1960

149

Primary Registration District No. 002 Registrar's No.

5892-60-041990 STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)	
a. COUNTY JACKSON	e. STATE MISSOURI COUNTY JACKSON		
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY	Length of stay in 1b 30 YRS.	c. CITY OR TOWN KANSAS CITY	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 1315 EUCLID		d. STREET ADDRESS (If outside, give location) 1315 EUCLID	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First ROBERT	Middle	Last FINE	4. DATE OF DEATH	Month 11	Day 20	Year 1960
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5. SEX MALE	6. COLOR OR RACE COLORED	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-4-1875	9. AGE (last birthday) 85	IF UNDER 1 YEAR	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY JOBS	11. BIRTHPLACE (City and state or country) PREASTON, KANS.	12. CITIZEN OF WHAT COUNTRY U.S.A.	Months	Days

13a. FATHER'S NAME ED FINE	13b. MOTHER'S MAIDEN NAME SARAH	14. NAME OF HUSBAND OR WIFE DONT KNOW
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNKNOWN	16. SOCIAL SECURITY NO. 496-09-2259	17. INFORMANT MRS. B.D. FINE, K.C., MO.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Myocardial Insufficiency		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) Arteriosclerosis		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senility		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY	Hour	Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE M. Tillman, Deputy Coroner	22b. ADDRESS 1618 Lydia Ave	22c. DATE SIGNED 11/22/60
23a. BIRTH, CREMATION, REMOVAL (Specify)	23b. DATE 11-29-60	23c. NAME OF CEMETERY OR CREMATORY H.C. College of Naturopathy, K.C. Mo.
24. FUNERAL DIRECTOR BROWN-HUDSON, K.C., MO.	25. DATE RECD. BY LOCAL REG. 11-23-60	26. REGISTRAR'S SIGNATURE H-L Dwyer

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF M. Tillman

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.